ogical
Medical
Serials

STORAGE

THE HOSPITAL GAZETTE AND ARCHIVES OF CLINICAL SURGERY.

A Semi-Monthly Journal of Medicine and Surgery.

VOL. 3, NO. 4.
WHOLE NO. 24.
NEW YORK, FEBRUARY 15th, 1878.
SUBSCRIPTION, $1.50 per year, post-paid.

Special Notice!!

With each issue of the HOSPITAL GAZETTE we send out

1000 Specimen Copies

to non-subscribers in all parts of the country; whose attention we invite to the following features of this periodical:—It is published every fifteen days, making 24 numbers in the year, for $1.50 including postage. Each number contains 24 closely printed pages of valuable reading matter, from the pens of the ablest and most distinguished members of the profession. It is the only journal that furnishes regularly Didactic and Clinical Lectures, Hospital Records and authoritative Abstracts. All departments of a well conducted periodical are represented. It is fearless and independent in its reviews and editorials. It is the cheapest journal published.

Try it for one year, and you will subscribe indefinitely.

Vitalized Phosphates.

(Prepared according to Dr. Samuel R. Percy's Formula.)

A BRAIN AND NERVE FOOD.

A PROXIMATE PRINCIPLE, i. e., "a substance, whether simple or compound, which exists under its own form in the solids or fluids of healthy animals."

Prepared from the Germ of the Wheat and the Brain of the Ox, forming Oleo-nitrogenous Hypophosphites and Protagon, as they exist in the human brain and nerves.

This preparation has now been before the profession long enough to be known and appreciated. Over 100,000 bottles have been disposed of by order of physicians alone, without an advertisement of any kind, giving relief in

Consumption, Dyspepsia, Wasting Diseases, Loss of Memory, Nervous Complaints, &c., &c.

As imitations of many kinds, and in various names, are offered to the profession, we would caution physicians against using any but "VITALIZED PHOSPHATES" bearing the names of

F. CROSBY, Chemist, and CASWELL, HAZARD & CO., General Agents,

Can be obtained at any respectable Drug Store.

THE LOUISVILLE MEDICAL NEWS

FOR 1878.

Every Saturday.

R. O. Cowling, M. D. }
L. P. Yandell, Jr., M. D. } Editors.

John P. Morton & Co., Publishers,
23[illegible] Main St., Louisville, Ky.

The Louisville Medical News enters its fifth volume in January. It has steadily increased in circulation and influence since its commencement, and ranks among the leading journals of the country.

It is published with unfailing regularity every Saturday morning.

It is the only weekly medical journal south of the Ohio, and one of the five in the United States.

It contains Clinical Lectures and Reports, Original Papers, Reviews, Correspondence, Formularies, Selections from Home and Foreign Journals, Editorials on Current Topics, etc., etc.

The best talent of the country has been engaged to write for its columns, and every effort will be made to keep up and to increase its interest during this year.

Terms of Subscription, $3.00 in advance.

Specimen Copies sent one month, (four numbers), for 25 cents.

ADDRESS THE PUBLISHERS

THE HOSPITAL GAZETTE,

AND ARCHIVES OF CLINICAL SURGERY.

A Semi-Monthly Journal of Medicine and Surgery.

EDITED BY

Edward J. Bermingham, M. D., and Frederick A. Lyons, M. D.

Subscription, including postage, $1.50 per annum, invariably in advance.

This periodical was formed by the union of The Hospital Gazette and the Archives of Clinical Surgery, and retains the many excellent features of both of those journals. Each number consists of 24 large closely printed octavo pages, on paper of the finest quality. The editors are assisted by an able corps of collaborators and reporters, and no trouble or expense is spared to maintain it as the representative journal of the country. The following departments are represented:

LECTURES, clinical and didactic, delivered at the principal schools and hospitals, and reported expressly for this journal.

ORIGINAL ARTICLES of practical value to the general practitioner, contributed by the best writers in the profession.

TRANSLATIONS of lectures and papers of importance and interest.

HOSPITAL RECORDS:—A leading feature of this journal is a special department devoted to the publication of the interesting cases in our larger hospitals. The cases are given in full, with explanatory and critical remarks, thus attaining the dignity of original articles.

PERISCOPE, under which heading appears abstracts of valuable articles from the pages of our contemporaries; prepared by men eminent in the profession.

CORRESPONDENCE upon matters of moment to contributors.

MISCELLANEOUS ITEMS of general interest.

BIBLIOGRAPHICAL NOTICES of new works and editions, prepared by an able corps of impartial reviewers, and made solely in the interest of our readers, and not in that of any college, clique or publishing house.

Specimen copies sent *ONLY* on receipt of ten cents, which will be credited in case of subscription.

Address all communications, of whatever nature, to

"THE HOSPITAL GAZETTE,"
NEW YORK CITY.

TO THE MEDICAL PROFESSION

The undersigned begs to invite attention to a new and elegant preparation of

COD LIVER OIL

with Wild Cherry Bark and the Hypophosphites of Lime and Soda. Each fluid ounce contains:

Pure Norwegian Cod Liver Oil,	50 per cent.
Syrup Wild Cherry Bark,	25 "
Hypophosphite of Lime,	5 Grains.
Hypophosphite of Soda,	5 "

This emulsion contains nearly fifteen per cent. more oil than any other offered to the profession, and such is the care taken in its manufacture, that it will not decompose, or be percipitated by standing, as is so often the case. It is also elegantly flavored, and will be found to agree with the most delicate stomach.

In ordering, please specify "*Kress' Emuls. Ol. morrh. cum Pruni Virg.*"

Please inform your druggist that this preparation can be found at the wholesale houses of John F. Henry, Curran & Co., and Fraser & Lee.

HE ALSO KEEPS CONSTANTLY ON HAND A FULL LINE OF

REYNAL'S MEDICATED BOUGIES.

Chloride of Zinc and Belladonna,
Chloride of Zinc and Opium,
Sulphate of Zinc and Belladonna,
Sulphate of Zinc and Opium,
Sulpho-Carbolate of Zinc.
Sulphate of Zinc,
Tannin,
Ext. Rhatany,
Sulphate of Soda,
Chloride of Zinc,
Extract of Opium,

These Bougies have been extensively used in the treatment of blennorrhoea both acute and chronic, with the most gratifying results abroad, and are now introduced into this country.

FLUID EXTRACT OF DAMIANA,

A Powerful Aphrodisiac.

SUGAR COATED PILLS, COMPRESSED PILLS,
GELATINE COATED PILLS, MEDICINAL WAFERS,
AND ALL NEW PREPARATIONS.

ALL FOREIGN AND NATIVE, NATURAL AND ARTIFICIAL MINERAL WATERS CONSTANTLY ON HAND.

Prescriptions a Specialty.

PRESCRIPTIONS ACCURATELY PREPARED from the Purest Medicines and compounded at all hours of the day or night.

Orders sent to *any part* of the country.

OSCAR KRESS,
Analytical and Dispensing Chemist,
Cor. 52d Street & Broadway, N. Y.

Total Abstinence Saving Wine Till it Ripens.

There is a curious story about some native wines which are extensively advertised nowadays, and have only recently been put upon the market. Dr. Underhill, the well-known grape-grower of Croton Point, died in 1871. Some of his heirs entertained temperance views of such extreme kind, that they were unwilling to allow the stock of wines then on hand to be sold or any more to be made. The grapes have sometimes been sent to market, and sometimes left to decay upon the vines. It is only now that the other heirs have succeeded in arranging for a settlement of the estate and a sale of the wines on hand. Among these is a wine of the vintage of 1864, described as a "Sweet Union Port," but suggesting the Imperial Tokay more than any other European wine, and being wholly unlike any other wine of American Growth. Its purity, age and mellowness are remarkable, and both physicians and wine-fanciers have a special interest in it as the oldest native wine now accessible in any considerable quantity. The whole stock is in the hands of the well-known wholesale grocery house of the Thurbers.—*N. Y. Tribune, Nov. 19th, 1877.*

The above speaks for itself, but we would add that this is the pure juice of the grape, neither *drugged, liquored* nor *watered;* that it has been ripened and mellowed by age, and for medicinal or sacramental purposes it is unsurpassed. It can be obtained from most of the leading Druggists throughout the United States, and at wholesale from the undersigned, who will forward descriptive pamphlet, free of charge on application.

Respectfully, etc.

H. K. & F. B. THURBER & CO.

West Broadway, Reade and Hudson Streets,

NEW YORK.

Physicians can refer their patients to any of the leading retail druggists in New York, Brooklyn, or Jersey City, for the above.

THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY.

A Semi-Monthly Journal of Medicine and Surgery,

EDITED BY

EDWARD J. BERMINGHAM, M. D., and FREDERICK A. LYONS, M. D.

VOL. 3, NO. 4. NEW YORK, FEBRUARY 15TH, 1878. WHOLE NO. 24.

CONTENTS.

LECTURES.—Clinical Lecture on New Remedies; by Jacob M. Da Costa, M. D, I. Chrysophanic Acid in Chronic Psoriasis, [77.] II. Ergot in Diabetes Insipidus, [78.] III. Jaborandi in Pleural Effusion, [79.] Lectures on Compound Comminuted Fracture of Right Elbow, and Dislocation of Right Humerus, with Post-Mortem Examination; by Jarvis S. Wight, M. D., [81.] Clinical Lecture on Angina Pectoris; by John B. Roberts, M. D., [87.] ORIGINAL ARTICLES.—Spontaneous Amputation of a Gangrenous Leg at the Knee-Joint, under the Hot Water Treatment; by Frank H. Hamilton, M. D., [91.] Notes on the Local Treatment of Blennorrhœa; by J. E. M. Lordly, M. D., [93.] The Use of Chloral, Surgically; by Maurice J. Lewi, M. D., [95.] HOSPITAL RECORDS.—Roosevelt Hospital, New York. *Reported by Dr. W. B. Berry.* Ligation of Femoral Artery for Popliteal Aneurism, Lister's Antiseptic Method, [96.] Contusion of Back and Chest—Peritonitis—Death, [98.] ABOUT BOOKS.—A Practical Treatise on Materia Medica and Therapeutics; by Robert Bartholow, M. A., M. D., [100.]

◆

LECTURES.

CLINICAL LECTURE ON NEW REMEDIES,

Delivered at the Pennsylvania Hospital,

BY

JACOB M. DA COSTA, M. D.,

Professor of the Theory and Practice of Medicine in the Jefferson Medical School, Philadelphia.

I. CHRYSOPHANIC ACID IN CHRONIC PSORIASIS. II. ERGOT IN DIABETES INSIPIDUS. III. JABORANDI IN PLEURAL EFFUSION.

To-day's lecture might, with propriety, be called a clinic of new remedies. I wish to call your attention to three very interesting cases in which new remedies have been successfully employed.

CHRYSOPHANIC ACID IN CHRONIC PSORIASIS.

J. B., aged 27, a teamster by occupation. The history of this case extends a long way back. The patient tells us that during the hot weather of July, 1867, his hair all fell out and an eruption appeared on his scalp. He says that he thinks he contracted the disease from a friend, (not a female friend,) who was afflicted in the same way. He utterly denies any syphilitic contagion, says that he never had any sore throat, and that there were none of the other constitutional symptoms present. After several months had passed, the eruption left his head, and the hair grew again thickly. There was no local application made at the time, except salt and water, and no internal treatment whatsoever. After leaving his head, the eruption appeared on his legs, and has remained there ever since. About six months ago he was admitted to the hospital for the first time. His arms, legs and trunk, were then covered with the eruption. This eruption was reddish and scaly; the skin was thickened, brazed, and fissured. The eruption was least visible upon the scalp and forehead, and was most characteristic about the joints, particularly the elbow joints. The man had been using a great variety of remedies with no success at all. Among other things he had tried arsenic, in the form of arsenious acid, and also the so-called "Asiatic pill," but everything failed utterly to do him any permanent good.

I then determined to make trial of a remedy which I had seen highly recommended in one of the English journals, viz: chrysophanic acid ointment. I used the ointment with a strength of one drachm of the acid to one ounce of simple cerate, and caused it to be well rubbed into the skin of the whole body every evening. After several days' use of this ointment, the skin became much paler and smoother, and the scales began to disappear. Unfortunately the man took it into his head to leave us just at this juncture, and he has been entirely lost to our sight until to-day, when he again came back to the hospital, and I hope will stay with us long enough to enable us to thoroughly test the value of this new remedy.

Now that he is stripped, you see what a marked case of the disease he presents. There is no healthy skin left upon the body, except upon the front and upper part of the chest, the face, forehead, scalp, and hands, all the rest of the body is covered with rough, uneven, reddish scales. You see that the eruption presents the most typical character, just about the elbow joints. The case is not nearly so bad to-day, however, as when we began the treatment.

I shall place the man once more upon chrysophanic acid. For purposes of cleanliness merely, I shall order him a lukewarm bath daily, in which he must remain for ten or fifteen minutes. After his baths I will have him rapidly, but thoroughly, dried. During the second week of treatment, I will have the bath rendered very slightly alkaline, by putting, say one-half ounce of the carbonate of potassium into the water. Then I shall cause the man to rub the chrysophanic acid ointment carefully into the skin of his whole body. Every evening, in the course of a few applications, I think the improvement will be marked.

ERGOT IN DIABETES INSIPIDUS.

This man was admitted to the hospital on November 26th, 1877.

He was then in very poor health, complaining of the daily passage of very large quantities of urine—ten pints daily. He was only moderately thirsty, and averred positively that he passed more water than he drank. The loss of flesh was marked, and there was some irritation of the neck of the bladder. His bladder had been upon several occasions sounded for calculi, but none had been found. Under my direction, the case was carefully watched, and it did really seem as if the outgo was greater than the income of water—the man passed daily ten pints by actual measurement. There was not a particle of sugar or albumen in the urine. I at once recognized the case as one of diabetes insipidus, or polyuria. This disease consists in the passage of large quantities of urine, containing no albumen nor sugar, and is attended by wasting as in true diabetes. It is often found in combination with actual disease of the nervous system, and is generally a condition very difficult of eradication.

As a venture, and upon general principles, I placed the man upon fluid extract of ergot, which treatment had been followed by striking success, *i. e.*, complete cure, in two cases in my private practice. I put him upon an initial dose of half a drachm of the fluid extract, thrice daily, the dose to be increased gradually; increased in size, first, to one drachm, and then to two drachms. There was at once apparent, a great reduction in the quantity of urine passed daily. From ten pints it fell to six pints daily, then to three, where it now stands. Even before reaching the present limit, I ordered the dose to be gradually reduced in size, first to one drachm, and then to half a drachm. Then it was stopped altogether, and mint water substituted in its place. This mint water, employed as a slight stomachic, is all that the man is now taking. For the past two weeks, he has had no ergot, and I may, therefore, consider him permanently cured. The amount of urine daily passed varies between two and three pints, that is, the amount is just about normal. Within the past week, he has had an operation for phimosis performed on him by the resident surgeon, which he has stood very well. He leaves the hospital, to-day, entirely cured, and strong—feeling better than ever in his life before, so that I have every reason to hope that the cure will be permanent. For the last two or three days, the man has been taking a tablespoonful of cod-liver oil, thrice daily—this to strengthen his digestion and general system.

JABORANDI IN PLEURAL EFFUSION.

I. L. C., aged 23, a weaver by trade, was much exposed last summer to wet weather, while at the seashore. Has had occasional cough and pains in the left chest, during the fall. The pain was, at times, so severe, that he had to lean his breast against a beam while weaving. These pains finally rendered it necessary for him to give up his trade. Within the past four or five months, he has had dyspnœa, and has noticed blood in his sputa. Three months ago, he was admitted to another hospital in this city. While there, his thoracic symptoms were found to depend upon the presence of a large pleuritic effusion. Aspiration was performed; and thirty-six ounces of a clear, serous fluid was drawn off. After this operation, the shortness of breath, chills and pain speedily ceased, and he was discharged, apparently well. Since then, there seems to have been a return of the effusion, for he tells us that the pains and dyspnœa came on again.

He was admitted to this hospital on December 29th of last year, suffering from severe pain and dyspnœa, chills, and general wretchedness. His temperature was 101°, and percussion showed that his left chest was full of fluid. I was tempted to perform aspiration at once, a second time, for the effusion extended very high up, and his heart was pushed far over to the right; the expiratory murmur also was very feeble. I have, however, so often been able to notice the fact, that when aspiration is performed more than once, the effused fluid is exceedingly likely to become purulent, and so give rise to empyema, that I determined not to attempt surgical interference a second time, but to try a remedy which some French clinicians have lately used in cases of pleurisy with very great success, viz., jaborandi. I therefore ordered the patient one drachm of the fluid extract of jaborandi, four times daily. The results have been truly marvelous. For nearly a week, his temperature has been down to 98°–99°, the chills, pain, and dyspnœa, have altogether left him; his pulse has fallen to 86–96, per minute, and his respiration to 20. As regards the physical signs, I may state that there is no dullness upon percussion, except at the very bottom of the chest, and that the respiratory murmur is clear as far down as a level three inches below the angle of the scapula, that is to say, the murmur is only feeble over the spot of dullness. The effusion has, therefore, almost entirely disappeared. There is not more than one-quarter of an inch difference between the measurements of the two sides.

The patient has been sweating profusely while under the jaborandi treatment, so that I have no doubt at all that a large part of the effusion has been drawn off through the pores of the skin. He has also passed water very freely. The jaborandi has plainly done good by means of its diuretic and diaphoretic action. The result is most gratifying to me. The man is practically cured, and what is better, I think his cure will be permanent. In general, it may be laid down as a common fact, that fluid removed from the chest by medicinal means is far less likely to recur than if removed by surgical interference, that is, by aspiration. Do not understand me as taking a position againt aspiration, it is a most valuable therapeutic agent, and I often employ it, but I advise you always to use it as a last resort, where symptoms of dyspnœa and cardiac disturbance are urgent, and to try first in every case to treat the patient medicinally.

LECTURES ON COMPOUND COMMINUTED FRACTURE OF RIGHT ELBOW, AND DISLOCATION OF RIGHT HUMERUS, WITH POST-MORTEM EXAMINATION.

BY
JARVIS S. WIGHT, M. D.,
Professor of Surgery in the Long Island College Hospital, Brooklyn, N. Y.

Gentlemen—I have summoned you here at this hour, 8 P. M., to see an African negro who has been very severely injured. He is the steward of a ship; he is sixty-one years of age; he fell through the hatchway, from the deck into the hold, upon some slates that were laid in with their edges up, a distance of about twelve feet.

First—He has, as you see, a transverse supra-condyloid fracture of the left femur, and I call your attention to the fact that he had sixteen years ago a fracture of the neck of the left femur, followed by considerable shortening.

Second—He has some contusion of the head; the pupils are dilated, but there are no indications of serious injury to the brain.

Third—There is a compound, comminuted fracture at the right elbow-joint, involving the radius, the ulna, and the humerus. The opening is small, and over the olecranon.

Fourth—The head of the right humerus is dislocated. The greater tuberosity is under the coracoid process, and the head of the humerus projects beyond into the axilla.

Fifth—There is great shock. The molecular effect of the fall has disturbed the organic relations of the nervous system, rudely interfering with the circulation. In order to arrest, in some measure, the depression, the patient has had hypodermic injections of whiskey, from one-half to one drachm at a time.

It very rarely happens that the head of the humerus is dislocated on the dorsum of the scapula. This subject need not detain us at present. *In the great majority of cases the head of the humerus is dislocated into some part of the axilla.* Remember the boundaries of the axilla and you will realize the truth of this statement. The upper end of the dislocated humerus may be (1) under the neck of the scapula; (2) under the coracoid process; or (3) under the clavicle.

First—In the sub-glenoid dislocation the head of the humerus is in front of the latissimus dorsi, which is the posterior boundary of the axilla; it is above the floor of the axilla; and it is, therefore, practically in the axilla.

Second—In the sub-coracoid dislocation the head of the humerus is back of the pectoralis major, which is the anterior boundary of the axilla; it is above the floor of the axilla; and it is, therefore, practically in the axilla.

Third—In the sub-clavicular dislocation the head of the humerus is under the pectoralis major; it is in front of the scapula; and it is, therefore, in the axilla.

Admit that the walls of the axilla in these three instances may be somewhat displaced, yet practically the head of the humerus does not go out of the axillary space.

And this gives us a very simple principle of classification. The head of the humerus is dislocated into the axilla, (1) under the neck of the scapula; (2) under the coracoid process; and (3) under the clavicle.

Shall we reduce this dislocation while the patient is in a state of continued shock? Yes, if he can take ether; for sometimes ether will mitigate the severity of shock. Let me remind you that it is perilous to give chloroform to an African negro—a lesson taught me by experience. See how readily and kindly our patient goes under the influence of ether. My clinical assistant will now support on his hands this mangled limb in the most careful and tender manner, and leave me the upper part of the arm for manipulation. The nurse brings me a soft pillow of medium size, such as you can get in every house. I place this pillow gently between the arm and chest-wall, and put the bottom of my *stockinged* foot upon it, when I firmly grasp the sound part of the arm and pull outward and downward, at the same time pushing the pillow upward before my foot. The dislocated bone is reduced with great ease.

I now observe that the patient is very much depressed. He is almost in a state of collapse. To exsect the elbow-joint now would be full of peril to the patient; perhaps this may be done in the morning. I will put this injured arm in a right-angled trough of wire-cloth, well lined with oakum, applying carbolized oil to protect and quiet the contused and lacerated tissues. I will sustain the patient with wine and milk, and alleviate his pain with anodynes. The patient will be taken to his bed in the ward, and you will be told in the morning how he passed the night.

Before you go, let me explain to you some points in the mechanism of reducing a dislocation of the humerus. The pillow presses:

FIRST—*On the chest-wall,* which is quite immovable; and the scapula is attached to the chest-wall by firm fascia, by strong muscles, and by the clavicle; and the motions of the scapula are modified by these attachments.

SECOND—*On the pectoralis major muscle:* That is, the inferior fibres of this muscle. These fibres are made tense, and they have a tendency to pull the humerus inward and downward; but the pillow prevents the inward tendency. Hence, any motion coming from this cause must be downward.

THIRD—*On the latissimus dorsi muscle:* The fibres of this muscle are made tense by the pressure of the pillow, and they have a tendency to pull the humerus inward and downward; but the pillow prevents the inward tendency. Hence, any motion coming from this cause must be downward.

FOURTH—*On the pectoralis major and the latissimus dorsi.* The pillow presses upward, and may be looked upon as immovable. The hands of the surgeon pull downward on the arm: this draws upon the tendons of the great pectoral and the broad dorsal muscles. The fibres of these muscles are drawn around the pillow and the surgeon's foot, and the traction extends to the attachment of these muscles to the trunk. Hence, the force is applied so as to pull the trunk and the scapula with it upward. At the same time, the upper limb moves downward, and in the sub-glenoid dislocation, the head of the humerus is carried over the border of the glenoid cavity; in the sub-coracoid dislocation, the head of the humerus is liberated from the coracoid process and carried over the border of the glenoid cavity; and in the sub-clavicular dislocation, the head of the humerus is drawn downward under the coracoid process, and carried over the border of the glenoid cavity: hence the pectoralis major and the latissimus dorsi muscles may be made to assist in the reduction of a dislocation of the humerus. My practical observations are in accord with these statements.

FIFTH—*On the axillary border of the scapula.* Any pressure of the pillow on the axillary border of the scapula tends to move the upper end of the humerus outward toward the glenoid cavity, and the scapula upward.

SIXTH—*On the inner-side of the upper part of the arm;* and it pushes the head of the humerus away from the chest-wall by antagonizing the teres major, the sub-scapularis, and especially the middle fibres of the pectoralis major. Any motion coming from this cause is away from the chest-wall towards the glenoid cavity.

In the mean time, remember that the lower end of the arm is abducted and elevated, by which the deltoid, and any remains of the supra-spinatus, are relaxed, and the untorn part of the capsular ligament is "taken off the stretch."

When the pillow begins to press upon the arm, the arm must be rotated outward. This, as you can readily see, prevents any severe pressure on the axillary vessels and nerves, by turning them out of the way, and it turns the head of the humerus towards the glenoid cavity. *And now traction on the arm, outward and downward by the surgeon's hands, brings into play all the forces above described, and the head of the humerus is induced into the glenoid cavity;* and finally, as the reduction is completed, the entire upper limb is carried across the chest.

Gentlemen, I have to tell you, to-day, that our patient died about two o'clock this morning. If I had done more for him last evening he would have died on the table. It is our duty, at times, not to operate; you must do the best you can in the circumstances in which you are placed, and Sir Astley Cooper must do the best he can in the circumstances in which he is placed.

I shall omit the didactic lecture this morning, and occupy the hour investigating this injured upper limb. Let me direct your attention at first to the fracture: I will exsect the elbow-joint. The point of the knife is entered over the ulna, two inches below the olecranon, and now cuts through the soft parts for a distance of four inches directly upward. I feel the blade grating on the fragments of bone. The soft parts are separated by retractors; the fragments of bone are separated from the periosteum, and removed—it being necessary to extend the incision about two inches further towards the hand. Here are seventeen fragments, some are sharp-pointed, and some are rough. They comprise two inches of the lower end of the humerus, and about four inches of the upper ends of the radius and ulna—a loss of six inches of the bones of the upper limb. To lose six inches of the upper limb and save the hand, is better than to lose the hand. And now if this cadaver were a patient it would be advantageous to put what there is left of his upper limb on a posterior double-angled splint, such as you have seen me use for compound fractures of the forearm.

In the second place, let me direct your attention to the right shoulder. You will not often have an opportunity like this to study the pathology of a dislocation. The work before us is to determine what structures about the shoulder-joint have been injured in this case. Let me call your attention to the fact, that there is rigor mortis. This need not detain us now. It may somewhat interfere with our investigations. The knife is inserted over the acromion, and an incision four or five inches long is made through the deltoid in a direction downward, upon the greater tuberosity and the shaft of the humerus. One part of the deltoid is drawn forward, and the other part is drawn backward, and the incision is extended above and below, so as to give room for complete observation. You will observe that the tendon of the teres minor muscle is torn from the greater tuberosity of the humerus. The muscular fibres of the infra-spinatus are lacerated, and there is some extravasated blood among them. The muscular fibres of the supra-spinatus are very much lacerated, and the tendon is mostly torn from the greater tuberosity. Among these structures is extravasated blood. The capsular ligament of the shoulder-joint is intact over the greater tuberosity of the humerus. I now put my finger into the posterior part of the opening we have made, and find the capsular ligament torn from the neck of the humerus, as far forward as the posterior limit of the greater tuberosity. And I now put my finger into the anterior part of the opening we have made, and find the capsular ligament torn from the neck of the humerus nearly as far outward as the greater tuberosity—some fibres being still attached to the lesser tuberosity. The head of the humerus remains firmly in the glenoid cavity.

The circumference of the humerus at the anatomical neck is from five to six inches; the greater tuberosity takes up about two inches, the lesser tuberosity and the bicipital groove take up about one inch, so that from the greater to the lesser tuberosity internally there would be about three inches of the anatomical neck of the humerus. Hence, in this case more than one-half of the capsular ligament has been torn from the humerus—transversely to the axis of the shaft of the bone; and through this rent the head of the humerus was driven at the time of its dislocation.

I will now cut the intact portion, less than one-half of the capsular ligament, and the head of the humerus is liberated. It readily goes into the axilla; observe how the greater tuberosity gets under the coracoid process, while the head of the humerus projects beyond it. See the long tendon of the biceps comes out of the bicipital groove, being still attached to the scapula. It is dislocated. Now put the head of the humerus back into the glenoid cavity, and the long tendon of the biceps resumes its place in the bicipital groove. How can we interpret these facts? Why, in this case there must have been a dislocation of the long tendon of the biceps, and last evening, when I reduced the dislocated humerus, the dislocated tendon of the biceps must have been reduced also. Does this tendon break away from its scapular attachment, or is it dislocated when the humerus is dislocated? This is a very difficult question to answer. So far as I can now judge, the long tendon of the biceps is more likely to be torn from the bicipital groove than from the scapular attachment. Let me now show you the lacerated fibres of the sub-scapularis. Note the very considerable extravasation extending from the inner aspect of the humerus into the tissues of the axilla. From this exhibition you can get an idea of the very considerable injury done to the peri-articular structures by a dislocation.

And now let me call your attention to some anatomical points and mechanical questions of importance in regard to the reduction of dislocations of the humerus.

First—The acromion projects beyond the glenoid cavity, on the average about two inches, sometimes beyond the greater tuberosity; sometimes even with it, and sometimes not so far as this process; generally the extremity of the acromion is directly over the greater tuberosity of the humerus.

Second—There is but very little space between the upper end of the humerus and the acromion process. The acromion protects the upper end of the humerus, and limits the upward motion of the arm.

Third—The anatomical neck of the humerus is very short, and meets the axis of the shaft of the humerus at an angle of about forty degrees. The anatomical neck and the surgical neck very nearly meet on the inner side of the humerus.

Now let us abduct the arm and elevate it. It goes readily, till the axis of the humerus is nearly at a right angle with the axis of the body, when you see it will not go further, *because the greater tuberosity comes in contact with the acromion.* Let us try to move this arm further upward; see the head of the humerus is pushed out of the glenoid cavity. The greater tuberosity is the fulcrum; the distance from it to the elbow is the power-arm of the lever; and the anatomical neck is the weight-arm of the lever. Approximately ten pounds applied to the lower end of the arm, the greater tuberosity being against the acromion, would overcome one hundred pounds of resistance before the head of the humerus. Hence, immense force can be applied to the capsular ligament, by abducting and elevating the arm.

This nurse has removed the clothing from his right shoulder, in order that I may demonstrate to you the facts. His arm may be elevated about to a right angle with the body, where it is arrested. Hold the scapula immovable and the arm will not go up higher; let go the scapula and the arm will move up somewhat higher, *because the scapula is tilted upward as the elbow moves upward.* So much for these motions when the parts are in a normal condition, but the same principles control the motions of the dislocated humerus, as we shall soon make plain.

In another relation, the facts are different. Do not forget that the humerus will rotate through an arc of about 90°. Now, let us elevate the arm, and *supinate* it at the same time. (1) The head of the humerus rotates in the glenoid cavity; (2) The greater tuberosity is turned away from the acromion toward the axilla; (3) the acromion projects against the surgical neck of the humerus on the inner side; (4) the head of the humerus projects under the acromion, being turned, as it were, upside down, in the glenoid cavity; (5) the scapula is tilted upward; and (6) the upper limb is found to be somewhat directly upward.

In the next place, suppose we have any one of the forms of dislocations at the shoulder that we have denominated *axillary.* The head of the dislocated humerus in general, will look nearly in the same direction as it did before displacement, that is, toward the chest-wall. Now abduct and elevate the dislocated humerus. The greater tuberosity and the outer side of the upper end of the shaft will move toward the glenoid cavity; the head of the humerus will continue to look directly away from the glenoid cavity; and the upper motion of the arm will be arrested by the acromion process. *Under such conditions, the head of the humerus will not go into the glenoid cavity.*

Please to remember that the humerus is dislocated, that the arm is abducted and elevated, and that the head of the humerus looks away from the glenoid cavity; the humerus is, as it were, turned inside out. You will now observe that *supination* of the arm will turn the head of the humerous forward, inward, and backward, toward the glenoid cavity; but *supination* will sometimes enable the surgeon to reduce the dislocation, and sometimes it will not enable him to do so. I have succeeded, and I have failed to reduce a dislocation of the humerus by these manipulations. The failure may have been due to: (1) the downward traction of the pectoralis major, and the latissimus dorsi; (2) the entanglement of the head of the humerus by the sub-scapularis; (3) the obstruction offered by the untorn portion of the capsular ligament; but I have not as yet been able to satisfy myself as to the primitive causes of failure under the circumstances.

It must, however, be admitted that the upward traction on the arm, combined with rotation, is a most effective way to break up the adhesions of an ancient dislocation, and it may be as dangerous as it is effective, but even then it will not always reduce the dislocation. And after the adhesions have been broken up I have made the reduction by abducting and elevating the arm, rotating it outward and lifting the upper end of the arm away from the chest-wall out of the axilla, so that we come back to the classical method of reducing a dislocation of the humerus.

Let me allude to another point that has received much attention. I refer to the resistance to reduction made by the untorn portion of the capsular ligament. I am speaking now of the shoulder-joint. There are two facts that you already know, viz.:

First—Complete anæsthesia will relax muscular fibres.

Second—Complete anæsthesia will not relax ligamentous fibres.

There are two other facts that have been repeatedly demonstrated by observation, viz.: the same means (1) when unaided by anæsthesia will fail to reduce a dislocation of the humerus; and (2) when aided by anæsthesia will accomplish the reduction of a dislocated humerus.

The anæsthesia has removed the muscular obstruction, and it has not removed the ligamentous obstruction; hence, the obstruction to reduction of a dislocated humerus is sometimes muscular, sometimes ligamentous, and sometimes both muscular and ligamentous. It is important to look at every side of a problem one is called upon to investigate.

Here I may add the following statement, namely, to abduct and elevate the elbow of a dislocated humerus and to lift the upper end of it away from the chest-wall out of the axilla will most effectually relax the untorn portion of the capsular ligament.

Finally, I had proposed to investigate the left hip-joint of this cadaver, but the friends interpose; they say we have done enough, and I must respect their objections and their feelings.

◆

A CLINICAL LECTURE ON ANGINA PECTORIS,

Delivered at the Jefferson Medical College Hospital of Philadelphia,
BY
JOHN B. ROBERTS, M. D.,
One of the Physicians to the Hospital.

I shall show you this morning, gentlemen, two cases which are interesting illustrations of a malady that is not very frequent, but is of great importance in a clinical point of view. First, let us hear the history of this man. John L., aged 32, comes to the hospital complaining of sudden paroxysms of severe pain in the cardiac region, which, he says, occur when he is hurried or excited, though sometimes they come on at night, so that he wakes in great pain and distress. The pain extends down both arms, but, he thinks, especially the left, and during the attack, he suffers from dryness of the mouth, and is afraid to take a deep breath lest it should increase the pain. The feeling of suffocation and the severity of the pain are such, that he feels as if he were going to die. This is the account of the attacks, which have of late rather increased in intensity; and, in addition, we find that he had some rheumatic trouble in his feet about seventeen years ago. Of course, these symptoms tell us to examine the chest, and finding nothing important in the lungs, we investigate the heart. The open beat is seen and felt outside of and below the left nipple, and on auscultation, there is perceived a loud, shrill murmur, diastolic in tune, and heard best in the vicinity of the aortic cartilage; in addition, there is heard a slight murmur with the systole of the heart. which is also most distinct at the right side of the sternum, near the second cartilage. · These murmurs are easily understood, if you recollect what should be the position of the aortic valves during the two sounds of the heart. During the first sound, the aortic leaflets should be widely open, and hence, murmur produced at that time indicates roughening, or some obstruction to the free exit of the blood current; with the second sound, however, the valves should be shut to prevent a reflux of the blood; but as we have a loud prolonged murmur at the orifice during diastole, it is evident that there must be free regurgitation. This is further substantiated by the character of the radial pulse, which strikes the finger with considerable force, but suddenly sinks away again, or, as we say, receding. Finally, the increased size of the heart, without a corresponding augmentation of the force of the impulse, renders it probable that dilatation exists as a consequence of the valvular lesions. Having thus determined that this patient has dilated heart, with regurgitation at the aortic orifice, and, perhaps, a slight amount of roughening, let us turn to the woman who comes with somewhat similar symptoms.

She is thirty-eight years of age, and says she has palpitation of the heart, and paroxysmal pain which is severe and shoots down her arms. These attacks are produced by any excitement, and during them, she becomes unconscious. She has never had rheumatism, and though nervous, has never been hysterical, and does not belong to an hysterical family, at least, not in the ordinary acceptation of the word hysterical. Examination of the lungs show signs of some consolidation at the right apex. Over the cardiac area is heard a harsh systolic murmur, with its point of greatest intensity at the apex, though it is also heard at the aorta; but as heard then, it is probably a transmitted sound from the mitral orifice. You must recollect that the four valves of the heart are situated very near together, in fact, in a space small enough to be covered, perhaps, by a half dollar; hence, to distinguish at which valve the murmur is generated, it is necessary to place the stethescope at other points than over the anatomical seats of the valves. These points have been determined clinically, and are well known to you, viz., apex, ensiform cartilage, second right costal cartilage and second left costal cartilage, or rather in the interspaces just below these costal cartilages. There is in this heart a strong impulse which is somewhat extended, hence, hypertrophy may be supposed to exist. In other respects, the woman seems to be in good general health.

You have now the history of these cases, and a report on the condition of the heart in each. The characteristic symptoms at once suggest as the diagnosis angina pectoris, which is evidently correct in regard to the first patient, but must be accepted with a little more hesitation in the second instance.

Let us then discuss the symptoms, pathology, diagnosis, and treatment of this painful disease; and first let me give you a hint as to the name angina, which you hear applied to many diseases so different in character. From its derivation it means something that throttles or suffocates, and was accordingly, by the older writers, applied to many diseases, having dyspnœa or difficult respiration for a symptom. Now you understand why it was applied to various kinds of sore throat which are so distant in their relationship to angina pectoris. The disease is characterized by sudden lancinating pain, radiating from the præcardial region into the neck and arms, and accompanied by a sense of constriction. There is apparent dyspnœa, produced by the intense suffering, which makes the patient afraid to breathe, though if he be commanded to take a deep inspiration, he can do so, and may thus cut short the paroxysm. Such is the case with this man. The pain is apt to shoot down the arms, and is especially noticed in the left arm as a rule; occasionally, however, as in a case under my care a year or two ago, the pain seems to begin in the hands and afterwards proceeds to the cardiac region. The paroxysms of pain may be induced by any exertion or emotion which quickens the circulation, and it is not unusual for patients to have distressing dreams at night and to wake with intense pain, and the feeling of impending death which so generally characterizes the affection. The patient may suffer so exquisitely that syncope may occur, as is stated to be the case in the woman before you During the paroxysm the pulse may be greatly disturbed, while at other times its rhythm and force are not much interfered with. It has been stated that there is during the occurrence of angina pectoris a great difference in the strength of the pulse, felt in the two radial arteries, but this, I think, has hardly been fully established. The intervals between the attacks of pain are irregular, and usually the paroxysms increase in frequency and severity, until the patient at last succumbs to the disease in one of these attacks, or is carried off by some intercurrent affection.

If the heart of such a patient be examined, what do we find? Usually there is organic disease of the heart or aorta, but no one lesion seems to be always present. A good many cases show atheromatous change of the coronary arteries, others fatty degeneration of the muscular structure of the heart, while in other instances again there is valvular disease or aneurism of the aorta. It would seem that most instances occur when there is fatty degeneration of the cardiac walls.

or lesions at the aorta, such as regurgitation, liable to induce overdistension of the ventricles. The pain which is probably neuralgic in character, and connected with the cardiac plexus, whence it is reflected by pneumogastric and sympathetic branches, is experienced whenever emotion or excitement causes sufficient disturbance of the circulation to produce overdistension and consequent paralysis or spasm of the heart. Fortunately I am able to show you a specimen to-day, taken from a patient of Dr. Ingram, which presents not only a rare lesion of the heart, but is interesting as being derived from a man who died a few days ago in a paroxysm of angina. The doctor had seen the man some weeks previously in a typical attack, and there is hence no doubt as to the diagnosis of angina pectoris. He was sent for hurriedly, about two weeks ago, and found the patient dead. The heart is before you, but has not as yet been thoroughly examined with the microscope. It is somewhat dilated, and shows a number of growths situated in the wall of the right ventricle, one of which involves the tricuspid valve. The coronary arteries are patulous, and the valves, except the tricuspid, normal. Further examination will probably show fatty change in the muscular fibre of this organ, and it is probable that these growths are malignant. You see then that there is no constant lesion in angina pectoris, though there is generally perhaps some fatty transformation, alone or connected with other lesions. You have heard then something of the symptoms and pathology of angina, and have seen this most interesting specimen; it remains to discuss the differential diagnosis and the treatment.

Intercostal neuralgia, with palpitation of the heart, may be discriminated, as a rule, by the three spots of tenderness found in the course of the intercostal nerve, as well as by the less serious character of the pain. There is a rare affection, sometimes called cardiac epilepsy, similar to angina pectoris, but in such cases, there is unconsciousness, generally primarily, while in angina the unconsciousness, if it occurs at all, comes secondarily as a result of the exquisite pain. Hysterical women sometimes have symptoms allied to angina in connection with ordinary neuralgia of the chest walls, and may complain of intense pain, and even lose consciousness. Hence we must be careful in making the diagnosis, and learn all we can of the antecedent history of the patient. Indeed, in the woman just before you, I have not made up my mind yet as to the true nature of the case, and have therefore made in her case a provisional diagnosis, while in the man, who has been under observation longer, and presents symptoms of aortic regurgitation and dilatation, there is no doubt regarding the anginose character of his disease.

The treatment must vary according to whether you are called to the patient during the paroxysm or in the interval. When you find him suffering this intense pain, and afraid to breathe, order him to make an effort to respire, and assure him that it may relieve the pain, or at any rate will have little tendency to increase it. If the case be one of moderate severity, hot whiskey punch, or some aromatic, may relieve; or spirit of chloroform, or ether, may be administered. The best remedy, however, of all, is a full dose of morphia, say a half or three-quarters of a grain, hypodermically. Resort may be had to inhalations of chloroform or nitrite of amyl, which will probably be of service; but our great reliance in painful spasmodic affections is morphia, given subcutaneously. During the interim between the paroxysms, attend to the general health, tell the patient to avoid excitement; dyspepsia and all causes liable to induce a paroxysm; and relieve, if possible, the cardiac disease, or at least endeavor to prevent overdistention or overwork of the disabled organ. Arsenic, belladonna, and digitalis, may at times be found available, and will apparently prolong the interval. Bromide of ammonium has been recommended, and cases have been reported where it seemed to cure the predisposition to attacks of angina. This man has been taking bromide of sodium with a similar end in view, and as he has no doubt tried many other remedies; it shall be continued in order to give it a fair trial. The woman's case shall be investigated further to see if the affection be true angina pectoris or an hysterical disorder, and she can then be treated accordingly.

SPONTANEOUS AMPUTATION OF A GANGRENOUS LEG AT THE KNEE-JOINT, UNDER THE HOT WATER TREATMENT.*

SERVICE OF

DR. FRANK H. HAMILTON,

Bellevue Hospital.

December 18, 1877, John Meagher, aged about 25 years, a switchman on the Long Island Railroad, was run over by two platform cars. During three days, he remained under the care of a physician at Hunter's Point, refusing to submit to amputation.

December 21, he was admitted to my wards, Bellevue Hospital. My House-Surgeon, Dr. W. S. Halsted, who examined him at once, and who was throughout in immediate charge of him, reported to me that he was, on admission, pale, and a little bronzed—his breath had a slight saccharine odor, the surface of his body was cold, his pulse weak, thready and rapid. He was delirious, talking in a low voice and incoherently.

The right thigh had suffered a severe laceration just above the knee; the wound being about ten inches long, and closed by sutures. It was emitting a strong gangrenous odor. On removing the sutures, the underlying structures were found extensively contused, the bone bare, and the wound filled with masses of undetached gangrenous tissue.

His left thigh was broken about three inches above the knee-joint, the upper fragment penetrating the joint. The whole limb was cold, swollen, discolored, emphysematous and pulseless.

*Reported to the Surgical Section of the Academy of Medicine, Feb. 12, 1878.

His condition did not warrant an amputation. In this opinion, Dr. Wood and the House Staff concurred. A long splint was laid beside the broken limb and secured by bandages, heat applied to the extremities, a weak solution of carbolic acid was employed to correct the fœtor, and nourishment with stimulants were adminstered. Speedy death was anticipated.

On the following day, his mind was more clear, but he was still very feeble, and the gangrene was extending in both limbs. Amputation was advised, but the parents refused their consent.

December 23.—Gangrene still extending; in the left leg involving the whole limb as high as the knee, and a discoloration existing as high as the groin.

The entire left leg and thigh were now enveloped in cotton batting, saturated with hot water—water at about the temperature of one hundred and ten degrees of Fahrenheit—and the laceration on the right thigh was treated in the same manner. Outside of the cotton batting, each limb was enclosed in oiled silk, and the patient was made to repose on a sheet of oil-cloth.

From this time, December 23, to when the left leg was removed at the knee-joint, the hot water was renewed every twenty or thirty minutes, day and night.

December 25, the discoloration, suspected to indicate approaching gangrene, has nearly disappeared from the left thigh, above the fracture. A line of demarcation is forming at the knee-joint. Delirium abating He begins to take food. Rests well.

December 29, no delirium. Says he feels well.

January 6, 1878, nineteen days after the receipt of the injury, and thirteen days after the commencement of the hot water treatment, the separation at the left knee joint was so nearly completed that with my scissors I cut the remaining sloughy bands, and removed the leg, without inflicting pain or causing the loss of only a few drops of blood.

The gangrenous slough had already separated from the opposite thigh.

January 7, removed to a water bed, being threatened with a bed sore.

January 15, right knee painful and swollen, but on the following day a profuse discharge occurred from the wound above the knee—probably from the joint—and the patient was relieved.

January 22 to 31, three or four small abscesses appeared on right limb and were opened.

February 8, last report, patient gaining in strength; wounds healing on right limb. Lower fragment of femur, (left limb,) projecting, and the necrosed extremity of bone gradually separating from the shaft. The lower fragment, about four inches, including the joint surface, dead, but still hanging by two bands of living soft tissue. Granulations healthy and cicatrization progressing; water dressings discontinued when the leg separated; balsam of Peru being substituted. His final and complete recovery is now assured. Possibly after a time resection of the bone may be required to make a good stump, but probably not. The lower fragment might be removed at any time with the loss of a little blood, but it has been deemed advisable to wait until the patient's strength is better established.

This is not the first time that I have obtained a similar result from this plan of treatment, and while I am not prepared to say that it will always prove successful in arresting traumatic gangrene, and in securing a prompt separation of the dead parts, it is proper to say that the method always deserves a trial when amputation cannot safely be practised.

It is worthy of remark that from the second or third day after the commencement of the hot water applications, there was almost no apparent constitutional disturbance. The patient took no medicines.

A very excellent paper on this subject of Hot Water in Surgery has been written by Dr. Frederick E. Hyde, of this city, formerly my pupil, and published in the *Buffalo Medical Journal* for December, 1875. It may be found in a pamphlet form at the publishing house of Wm. Wood & Co. In this paper, cases 6, 9, 10, 11 and 12 are examples of gangrene which were under my treatment, and which were arrested by hot water, and resulted in spontaneous amputation, and a cure.

NOTES ON THE LOCAL TREATMENT OF BLENNORRHŒA.

BY

J. E. M. LORDLY, M. D., New York.

Having kept a careful record of the last forty-two cases of blennorrhœa that have come under my observation, I beg leave to offer the results as obtained from local treatment, believing that blennorrhœa, acute or chronic, can be more successfully treated by this means alone than by internal remedies, combined with the small injections usually prescribed. It is, however, important that the injections and insufflations, which I advocate, should be made by the physician himself, and no patient should be allowed to have a syringe and use injections indiscriminately.

The plan of treatment adopted was as follows: A good fitting suspensory bandage was first applied, the bowels were kept regular by a saline cathartic; stimulating food and liquors were to be avoided. A copious warm medicated injection of about three pints was used every day, sometimes twice a day, and always after urinating. A large flask, containing the fluid to be injected, was suspended above the patient's head, and a No. 2 catheter, warmed and well lubricated with vaseline, was connected to the flask by several feet of small rubber tubing, the catheter was gently passed down to the prostatic portion of the urethra, and the fluid allowed to run slowly out. After the tenderness had somewhat subsided, or when the discharge had lasted some time, a greater pressure was used, by placing the flask at a higher level, and so distending the urethral canal and allowing the fluid to come in contact with the whole surface.

I have used, with equally good results, solution of chlorate of potash and sulpho-carbolate of zinc, in the proportion of one to three grains to the ounce, and when the tenderness was very great, an anodyne, such as extract of opium or belladonna, was used in the injection. Even in those acute cases the careful introduction of the catheter with a warm anodyne injection gave great relief.

After the injection, I applied astringent powders to the urethra, by insufflation. A small glass tube, about nine inches long and of sufficient strength, was passed gently down the whole length of the urethra. This tube is connected by a short piece of rubber tubing to a wide mouth bottle through the stopper; then air is forced into the bottle, by a hand bulb, through another short tube, which also passes through the stopper, the strong current of air passing into the bottle and out through the long glass tube, carries with it a portion of the powder which the bottle contains, and is deposited in the urethral canal, as the tube is slowly withdrawn.

The astringent powders are composed of tannin and sugar of milk, charcoal or starch, in different proportions, to suit the case. In chronic cases, equal parts are used with good results. The duration of the disease, previous to the time of treatment, varied very much; for instance, twenty-six patients had had a discharge for a time varying from two days to two weeks, while fourteen varied from two to six weeks, and two patients of intemperate habits had had a discharge of two months; nineteen patients had gonorrhœa for the first time, eight for the second time, and fifteen had had it several times.

Three patients had suppurating buboes, when they applied for treatment; nine had chancroids; four had indurated chancres, which were followed by secondary syphilis. Thirteen patients had one or more strictures in the urethra.

Local treatment gave the following results:

Four cases cured in one week.	Diseased for the first time, and from two to seven days before treatment was commenced.
Three cases cured in ten days.	
Seven cases cured in two weeks.	
Eight cases cured in three weeks.	
Seven cases cured in four weeks.	
Seven cases cured in six weeks.	Complicated with strictures.
Six cases cured in eight weeks.	

One patient, a fireman, neglected wearing his suspensory bandage, and had a swelled testicle, which was soon relieved by antiphlogistic treatment. All the patients followed their usual avocations, and were obliged to be on their feet during the entire time of treatment. If rest in the recumbent posture could have been employed, the cure would doubtless have occupied less time.

My limited experience in the treatment of gonorrhœa leads me to believe that it can be most successfully treated by the observance of the following points.

FIRST—The *personal supervision* of the treatment by the physician.

SECOND—The use of *copious*, warm, medicated injections, not to be stronger than three grains to the ounce.

THIRD—The application of a suitable astringent powder, that will remain in the urethral canal for a sufficient length of time to cause a healthy action to be taken on by the mucous membrane.

The above treatment necessarily implies time and patience on the part of the physician, but I think the result will be gratifying to both himself and patients.

◆

THE USE OF CHLORAL, SURGICALLY,*

BY
MAURICE J. LEWI, M. D.,
Resident Physician and Surgeon at the Albany Hospital.

And now, gentlemen, we go half-way with Mr. Lucas, and say : "What we can prove substantiates just about one-half of what you assert." Let it not be thought, however, by any of you that I am opposed to the use of this remedial, but to the contrary, I consider it one of the best local applications to ulcers, of the pharmacopœia, used with certain precautions and under certain rules, to which I shall now endeavor to call your attention.

FIRST—Have your solution 5 grs. to the ounce, ointment likewise.

Experience has proven that if this proportion be not efficacious, chloral is of no benefit in any larger or smaller proportion ; that is, if the ulcer do not respond to a 5-grain solution of chloral, it is certainly chloral-proof as far as healing is concerned, and injurious as to the system generally in larger quantities. In the proportion above mentioned, there are no ill-effects noticeable, and the uncomfortable itching, spoken of by so many writers on this subject, has, in the cases cited, been present but in one, and then to last but a short time.

SECOND—Apply by means of sheet or picked lint.

The soft, yielding character of the fabric allows granulations to sprout up under it, and in place of acting as a foreign body, actually takes the place of a scab, protecting the wound from the air, retaining perfectly the ointment or solution, as the case may be, and bringing the application directly in contact with the surface. In fistula, where healing from the base is desirable, it makes an excellent packing, keeping the lips of the wound from contact, at the same time allowing granulations to sprout up on all sides.

THIRD—Change dressing daily.

We have observed, in the use of chloral, that unless the dressings are changed daily, there is a great amount of unpleasant labor connected with scraping the ointment from the ulcer, which, if it remains on for a longer period than twenty-four hours, acts as a foreign body, and does harm instead of good; while with the solution applied by means of lint, this dries very soon, and the hardened lint also interferes with the favorable progress of the wound. Changing the dressings oftener than suggested can also be of little advantage, as the chloral undoubtedly retains its stimulating powers for that length of time.

---

* Read, before the Albany Academy of Medicine, January 7th, 1887.

FOURTH—Continue the treatment for only one week.

This last seems to us the most important point to be observed in the use of this drug in the treatment of wounds. The ulcer that has been awakened from its lethargy by the stimulating chloral, loses its power of responding out of habituation, and after a short time—never, however, less than a week—a stasis ensues, its sensibility to chloral becomes blunted, and instead of responding as at first in the form of healthy and encouraging granulations, the wound assumes an unhealthy appearance, the ulcer becomes indolent, and the good offices of the first week of its use are slowly but surely lost in the continued use of a now inert and possibly harmful drug.

HOSPITAL RECORDS.

ROOSEVELT HOSPITAL, NEW YORK.

Reported by W. B. BERRY, M. D., House Surgeon.

LIGATION OF FEMORAL ARTERY FOR POPLITEAL ANEURISM. LISTER'S ANTISEPTIC METHOD. SERVICE OF DR. MARKOE.

Robert Haskell, U. S., aet. 28, single, clerk. About one month ago patient noticed a certain pain and stiffness in the left knee joint, situated along the hamstrings. This pain was increased by exertion. Soon he noticed a swelling at the part hard and pulsating. It was about the size of an egg. His occupation has not called for any great muscular exertion, and he cannot remember having at any time strained the part. One week ago, while jumping from a car, he had sudden and severe pain in the joint, followed by rapid swelling. The limb below soon became œdematous. He went home, kept quiet, and the swelling did not increase. On admission, patient has a soft pulsating tumor in the left popliteal space. It does not seem to be clearly defined. Pressure on femoral artery does not seem to make any difference in size of tumor on pressure.

There is some œdema of the leg and foot. Pulsation in anterior and posterior tibial arteries not interfered with. Patient cannot move the knee without great pain; circumference of tumor seventeen inches.

Treatment.—Joint kept perfectly quiet by a bed of plaster of Paris and patient put on low diet: viz., two ounces of bread and two ounces of milk, three times a day, with two ounces rare beef at noon.

September 17.—Patient has no pain. The tumor remains about the original size, and it seems to be somewhat more hard.

September 18.—Given veratrum viride three drops, t. i. d.

September 20.—Weight of eight pounds of shot was placed so as to press on the artery, just above Poupart's ligament.

September 26.—The pulsation is reduced in force but is not entirely stopped by the pressure.

September 29.—By changing the adjustment of shot bag, pulsation is entirely stopped, but the patient is unable to bear continuous pressure. There is some œdema of foot and leg. Low diet discontinued.

October 3.—Weight increased to ten pounds. There is still pulsation when the bag is removed, but it is decidedly diminished. Circumference of tumor seventeen and five-eight inches, showing an increase of five-eight inches.

October 5.—Unable to bear pressure of bag but very little of the time. Pain intense. Pressure discontinued at night.

October 8.—Attacks of acute pain; much œdema in foot and leg. Size of tumor increasing; now measures little over eighteen inches.

October 9.—Size, eighteen and one-half inches.

October 10, 3 P. M.—Patient under ether.

Ligation of femoral artery performed by Dr. Markoe, assisted by Dr. Mason. An incision two inches in length was made over the position of sartorius muscle, at about apex of Scarpa's triangle. The skin, superficial, and deep fascia being cut through, the sartorius muscle, covered by its sheath, came into view. The sheath was divided, and what appeared to be the femoral artery appeared to the inner side of the muscle. This proved to be the femoral vein, the artery being felt pulsating more externally and more deeply. The femoral artery was then fully exposed for a short distance, by pushing aside the tissues, with the elevator on end of scalpel, and the aneurismal needle was then passed from within outward without difficulty. The artery was tied with carbolized cat-gut, and the ends cut short in the wound. Hemorrhage was but slight and readily checked. Edges of wound were brought together with carbolized gut, and Lister's dressing applied over all. Operation was done under spray; at end of the operation all pulsation had ceased in aneurismal sac, which felt soft and fluid. Patient removed to ward.

6 P. M.—Patient out of ether; complaining of very severe pain. Given hypodermic Majendie, ten minims.

October 11.—Pulse, 120; temperature, 99½. Wound redressed; discharge slight. No sign of irritation about wound. Lister renewed.

October 12.—Lister renewed; wound looking very quiet; circulation in limbs seems good. Aneurismal sac feels firm, but there is as yet no returning pulsation.

October 14.—Two remaining sutures removed. There is complete primary union. Pulse and temperature nearly normal. No recurrent pulsation in the tumor.

October 19.—Lister's dressing removed. There is complete primary union. Sheet lint and simple cerate used. There is very much less œdema of foot. Tumor seems firmer and of less size; *seventeen and one-fourth inches.*

October 26.—Patient sat up for short time. Cicatrix of incision very small and sound, but little œdema of leg remaining.

November 3.—Passive motion at knee joint made.

November 12.—Size of tumor *sixteen and seven-eight* inches. Motion at knee increasing.

November 25.—Tumor measures seventeen and three-eighth inches.

December 6.—Tumor measures seventeen and two-eighth inches. Freer movement at knee joint.

December 10.—Slight œdema of foot and leg still continue. Size of tumor sixteen and six-eighths inches; no pulsation, and motion at knee increasing.

December 12.—Discharged cured.

CONTUSION OF BACK AND CHEST.—PERITONITIS, DEATH.—SERVICE OF DR. SANDS.

Cornelius Cummings, United States, aet. 21; single; laborer. Patient was struck in back in the lower dorsal region, by barrel of cider, which fell down cellar stairway. The barrel also rolled upon him. On admission there is a mere contusion of back in lower dorsal region, with pain and sensativeness in left hypochondriac region. Some shock. *Treatment*—Rest maintained with morphia to relieve pain.

November 24.—Complains of much pain in abdomen which is sensative and somewhat tympanitic. Vomits green matter. Thoracic respiration, but is very restless. Pulse 108, temperature, 100°. Given sol. morph. sulph., U. S. P., one drachm every four hours.

November 25.—Still complains of pain in abdomen. Vomits but seldom. Bowels constipated since admission, with no movement.

November 26.—Appears better. Abdomen only sensitive in left hypochondriac region. Morphia is continued.

November 28.—Vomiting still continues, throwing off nearly everything. Complains of much pain and lies curled up most of time. Some peristaltic motion of bowels. Much flatus. Dullness over left hypochondriac region, which continues sensitive. Lower dorsal region of back at point of contusion still sensitive.

5 p. m.—Pulse 84. Temperature 100°. Respir. 22.

Morphia sufficient to keep quiet; ordered not to move the bowels or give injection. Given ice to relieve vomiting.

November 29.—Suffers much pain at night. Tympanitis continues, but vomiting has stopped. There is an increased area of dullness on left side; extending downward into left lumbar and umbilical regions. Fluctuation detected over this area of dullness, and hypodermic needle drew off a serous fluid, red in color and containing red blood corpuscles. No pus detected. Palpation detects fluid in abdomen. Morphia continued, with diet of eggs and spts. frumenti.

9 a. m.—Pulse 100. Temperature 99°. Respir. 16.

5 p. m.—Pulse 100. Temperature 100 2-5°. Respir. 20.

November 30.—Patient continues about same. Appears to suffer much colicky pain, but has not a depressed appearance. Pulse strong. Tongue moist. Vomiting has returned again, consisting of mucus and often what he eats. The area of dullness in abdomen gives an indistinct tumor.

Hypodermic of Magend., sol. morphia, eight minims, t. i. d., with one drachm doses of U. S., sufficient to keep down the respirations.

December 1.—Dullness in abdomen found to be descending, and now on a line with the umbilicus, and one and one-half inches to the left of it. It extends well up towards the ribs and into left lumbar region. By straining, patient had a small passage from the bowels to-day. Tympanitis continues. Vomiting better.

Urine.—Alk. 1026. Trace of albumen, uric acid, amorphous urates and traces of pus. Occasional trouble in passing his water, and silver catheter used.

8 p.m.—Pulse 136. Temperature 99 1-5°. Resp. 32. Vomiting has returned with much pain. Feels weak; pulse rapid and feeble. Morphia injections continued.

December 2.—Patient changed for the worse during the night. Appears in a state of collapse with profuse sweat and cold extremities. Pulse at wrist almost imperceptible. Given hypodermics, whiskey. Rectum cleaned out, and injections of beef tea extracts, one-half ounce to two ounces water, given; also milk and spts. frumenti, each one ounce. Vomits much of time. Tympanitis becoming excessive, but no œdema of lung detected.

6 p. m.—Pulse 108. Temperature 97 1-5°. Respir. 50.

Is evidently sinking rapidly.

8 p. m.—Patient died.

Autopsy.—Abdomen found to contain large quantity of bad smelling brownish black fluid; not purulent. Complete general peritonitis; the abdominal organs everywhere matted together by strong adhesions of fibrine and also everywhere united to the abdominal walls. The small intestine intensely congested and brownish black. The ascending and transverse colon gangrenous, with a rupture, (probably recent) two inches long, in the transverse colon just below stomach.

Slight effusion of blood in chest in cellular tissue over the heart in ant. mediastinum, also found post-pancreatic hæmatocele of large size, ruptured into peritoneal cavity.

◆

ABOUT BOOKS.

A Practical Treatise on Materia Medica and Therapeutics. By Roberts Bartholow, M. A., M. D. New and Enlarged Edition. New York. D. Appleton & Co., 1878.

The appearance of a new and enlarged edition of this valuable work, in such a short time after the first, is the best and most convincing evidence of the favor with which it has been received by the

W. L. HYDE & CO.,

Book and Job Printers,

114 East Fourteenth St.

Reparative Surgery:—By skilfully devised, adapted and approved apparatus and appliances, for compensative, and radical treatment of physical disabilities and deformities:—viz: Every variety and condition of **Amputated Limb**; Resections of inferior and superior extremities; Disunited fractures of femur and leg; Dislocations of knee and ankle joints; Chronic synovitis of knee and ankle joint; Hip disease; Spinal Curvatures; Ruptured ligaments and tendons of inferior extremity; Fractures of vertebræ; Paralysis of inferior and superior extremities; Lead paralysis; Talipes and congenital malformations. All apparatus philosophically, symmetrically, and efficiently adapted to fulfil the specific object.

E. D. Hudson, M. D., 1291 Broadway, N. Y.

Walter Ireland,
Subscription and Advertising Agent.

Subscriptions received for all American and Foreign Medical Journals. Clubbing rates given on application. Orders for Medical Books and Surgical Instruments promptly executed at dealers prices. Advertisements inserted in any Medical Journal at lowest rates.

Address, Station G, New York City.

The Chicago Medical Journal and Examiner,

(ESTABLISHED 1844.)

EDITOR:

WILLIAM H. BYFORD, A. M., M. D., Professor of Obstetrics and Diseases of Women and Children, Chicago Medical College.

ASSOCIATE EDITORS:

JAMES H. ETHRIDGE, M. D., Professor of Materia Medica and Medical Jurisprudence, Rush Medical College.

JAMES NEVINS HYDE, A. M., M. D., Professor of Dermatology and Orthopedic Surgery, Chicago Medical College.

NORMAN BRIDGE, M. D., Lecturer on the Principles and Practice of Medicine, Rush Med. Coll.

FERD. C. HOTZ, M. D., Surgeon to Illinois State Eye and Ear Infirmary.

ASSISTANT EDITOR:

E. FLETCHER INGALS, M. D., Lecturer on Diseases of the Chest and Physical Diagnosis, Rush Medical College.

ISSUED MONTHLY.

TWO VOLUMES A YEAR, BEGINNING WITH THE JANUARY AND JULY NUMBERS.

THE MEDICAL PRESS ASSOCIATION

Now publishes this Journal for the benefit of the CHICAGO MEDICAL LIBRARY.

The Journal contains thirteen hundred and forty-four pages each year. It is made up of original articles from some of the best talent of the country, with notes of interesting cases in hospital and private practice, and the editors receive every month more than a hundred of the leading medical journals of Great Britain, Ireland, France, Spain, Portugal, Italy, Prussia, Russia, Austria, Denmark, Australia, South America, Mexico, and the United States and Canada, from which they cull items of special interest. They give careful attention to the review of new books, and thus they furnish their readers all the current medical literature of the day. We shall spare no cost or pains to maintain the rank of this Journal with the best medical periodicals.

Terms:—$4.00 per annum. Single copies, 35 cents.

Postage Free. ***Subscriptions received for any period.***

Send all Subscriptions and Communications to the Assistant Editor.

E. FLETCHER INGALS, M. D.,
188 Clark Street, Chicago.

LACTOPEPTINE,

The most important remedial agent ever presented to the medical profession for Indigestion, Dyspepsia, and all diseases arising from imperfect nutrition, containing the five active agents of digestion, viz. Pepsin, Pancreatine, Diastase or Veg. Ptyalin, Lactic and Hydrochloric Acids, in combination with Sugar of Milk.

FORMULA OF LACTOPEPTINE.

Sugar of Milk	40 ounces.	Veg. Ptyalin or Diastase	4 drachm
Pepsin	8 "	Lactic Acid	5 fl. "
Pancreatine	6 "	Hydrochloric Acid	5 fl. "

LACTOPEPTINE owes its great success solely to the medical profession. and is sold almost entirely by Physicians' Prescriptions. Its present sale exceeds $100.000 per year at wholesale. Its almost universal adoption by the profession, as the above figures show, is the strongest guarantee we can give that its therapeutic value has been most thoroughly established.

The undersigned, having tested REED & CARNRICK's preparation of Pepsin, Pancreatine, Diastase, Lactic Acid, and Hydrochloric Acid, made according to published formula, and called LACTOPEPTINE, find that in those diseases of the stomach where the above remedies are indicated, it has proven itself a desirable, useful and well-adapted addition to the usual pharmaceutical preparations, and therefore recommend it to the profession.

NEW YORK, *April 6th*, 1875.

J. R. LEAMING, M. D.,
Attending Physician at St. Luke's Hospital.

ALFRED L. LOOMIS, M. D.,
Professor of Pathology and Practice of Medicine, University of the City of New York.

J. H. TYNDALL, M. D.,
Physician at St. Francis' Hospital.

LEWIS A. SAYRE, M. D.,
Professor of Orthopœdic Surgery and Clinical Surgery, Bellevue Hospital Medical College.

SAMUEL R. PERCY, M. D.,
Professor Materia Medica, New York Medical College.

JOSEPH E. WINTERS, M. D.,
Assistant Demonstrator of Anatomy, Bellevue Hospital Medical College.

F. LE ROY SATTERLEE, M. D.,
Prof. of Chem., Mat. Med. and Therap. in the N. Y. College of Dent.; Prof. of Chem. and Hygiene in the Am. Vet. College, &c., &c.

Price List.

LACTOPEPTINE (Powder, in oz. Bottles)	per oz.	$1 00
" (Powder, in oz. Bottles)	per doz.	10 00
" (Powder, in ½ lb. Bottles)	per lb.	12 00
Elixir Lactopeptine	per doz.	15 00
" Lactopeptine and Bismuth	"	15 00
" Lactopeptine, Strychnia and Bismuth	"	15 00
" Calisaya Bark and Iron, with Lactopeptine	"	15 00
Beef, Iron and Wine, with Lactopeptine	"	12 00
Liquid Lactopeptine	"	15 00
Syrup Lactopeptine Compound	"	15 00

All Correspondence and Communications must be Addressed to

The New York Pharmacal Association,

(Who have purchased all the rights in the article of Messrs. REED & CARNRICK.)

83 JOHN STREET, NEW YORK.

P. O. Box, 1574.

THE STANDARD

Electrical - Instruments,

FOR

MEDICAL PURPOSES,

Manufactured by

THE GALVANO-FARADIC M'F'G CO.

288 FOURTH AVENUE,

☞ Send for Illustrated Catalogue. New York.

PHILIP H. SCHMIDT,

(Twenty-five years with Geo. Tieman & Co.)

Manufacturer and Importer of

Surgical and Orthopædic Instruments,

TRUSSES, SUPPORTERS,

Elastic Stockings, Splints and Braces.

REPAIRS PROMPTLY ATTENDED TO:

1275 BROADWAY, Cor. 34th Street,

Over Drug Store. ——:o:—— NEW YORK.

Mrs. Schmidt will be in attendance to wait upon Lady customers.

PARRISH HALL,

A Private Medical Home for Opium Habitues, Brooklyn, N. Y.

This Home, the only one of its kind in existence—offers to those of either sex who may desire to avail themselves of its advantages, a remedial retreat, where they may secure radical release from the enslaving power of opiates.

Delightful location, near Prospect Park, overlooking City and suburbs. Handsomely furnished, and provided with those appliances which experience has proven valuable in the treatment of the disorder to which it is *exclusively* devoted.

Patients limited and select. No alcoholic subjects admitted. A full history required in all cases to determine prognosis. If favorable, they are accepted, and treatment entered upon with the strongest prospect of success. Terms for board and treatment according to size and location of apartments. No effort spared to make PARRISH HALL an attractive home for its inmates, and one with which pleasant recollections of restored health will always be associated, Details on application.

JOSEPH PARRISH, M. D., Burlington, N. J. } Consulting Physician.

J. B. MATTISON, M. D.
A. M, MATHIAS, M. D.
Late Ass't Physician "Sanitarium," Media, Pa.

BORATED COTTON

For Dressing Wounds and Ulcers.

"It is a very clean dressing and wounds seem to do well under it."—J. L. Little, M. D., Prof. Applied Surgery, Coll. P. and S., N. Y.

BORATED COTTON

For Tampons in Treatment of Catarrh of Uterus and Vagina, "Its therapeutic value is quite decided." *New Remedies.*

ANTISEPTIC GAUZE.

LISTER'S FORMULA.

The above For Sale at the principle Drug Stores and Instrument Makers. For Samples, ADDRESS,

C. Am ENDE, Hoboken, N. J.